CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return Surcharge	☐	$_____	_____
Additional Surcharge	☐	$_____	_____

Surcharge Change Reason: _____
_____

Health Care Provider (if d/b/a, must include full name or if multiple, attach list of all d/b/a's)	Medical License No. (Individual):
Email Address to send PCF Enrollment Confirmation:	EIN# /License# (Entity):
Address (Street, City, State, Zip):	

Policy No.:	Occurrence ☐ Claims Made ☐ Reporting Endors ☐	Retro Date (Form CM or RP)	Including employees ☐ Excluding employees ☐	ISO Code:

Coverage Dates: From: _____ To: _____	Limits of Liability: $_____ per occurrence $_____annual aggregate

Date Surcharge Rec'd from Provider:	IN P/L Premium Only:	Surcharge:	Pro-Rated ☐ 2nd Policy ☐ Locum ☐	Under 90 day Penalty:	Over 90 Day Penalty:

Following credits are available for health care providers identified under Rule 60 and only part-time credits are available to those providers identified as Independent Ancillary Providers per Rule 21:

Credits: **(Only one credit may be applied)**	Part-Time Credits ☐ 0-12 hrs. 75% ☐ 13-24 hrs. 50% ☐ 25-30 hrs 25%	Medical School Faculty ☐ 67% ☐ Retired	Newly Licensed Physicians ☐ 1st yr. 50% ☐ 2nd yr. 25%	Fellowship ☐ Full-Time 50% **Greater of:** ☐ Full-time surcharge for medical practice outside fellowship ☐ 50% of surcharge due for specialty class of fellowship

Insurance Carrier Name:	NAIC#

Contact Name: (Person Completing Form)	Telephone Number: Email:

The undersigned Insurance Company/Broker, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Medical Malpractice Act, Indiana Code 34-18-1-1 et seq.

I further certify that the surcharge for the above-referenced health care provider for the period specified in this policy is at the appropriate surcharge as designated by statute, rules, and IDOI bulletins. Said Company/Broker also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days of receipt from provider, but not more than sixty (60) days from the effective date of said policy.**

I further acknowledge that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20____ at the insurance office of _____

Authorized Signature:	Printed Name:	Title:

Pac-3/State Form 2713R5
Revised 5/17/2011